

REPORT OF THEFT OR LOSS OF CONTROLLED SUBSTANCES

Federal Regulations require registrants to submit a detailed report of any theft or loss of Controlled Substances to the Drug Enforcement Administration. Iowa Law requires the same report to the Iowa Board of Pharmacy.

Complete the front and back of this form in duplicate. Retain the duplicate copy for your records.

Submit the original report to: Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, IA 50309-4688.

The Pharmacy Board will submit a copy of the report to the local Drug Enforcement Administration office on your behalf.

1. Name and Address of Registrant (include street address and zip code)		2. Telephone (include Area Code)	
3. DEA Registration No.	4. Date of Theft/Loss	5. Principal Business of Registrant (check one) <input type="checkbox"/> Pharmacy <input type="checkbox"/> Distributor <input type="checkbox"/> Practitioner <input type="checkbox"/> Methadone Program <input type="checkbox"/> Manufacturer <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Hospital/Clinic	
3a. Iowa CSA Registration No.			
6. County in Which Registrant is Located	7. Was Theft Reported to Police? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Name, Telephone No. of Police Dept. (include Area Code)	
9. Number of Thefts/Losses Registrant has experienced in the past 24 months	10. Type of Theft/Loss (Check one and complete items below as appropriate) <input type="checkbox"/> Night Break-in <input type="checkbox"/> Customer Theft <input type="checkbox"/> Armed Robbery <input type="checkbox"/> Other (Explain) <input type="checkbox"/> Employee Pilferage <input type="checkbox"/> Lost in Transit (Complete Item 14)		
11. If Armed Robbery, was anyone: Killed? <input type="checkbox"/> No <input type="checkbox"/> Yes (How many) _____ Injured? <input type="checkbox"/> No <input type="checkbox"/> Yes (How many) _____		12. Purchase value to Registrant of Controlled Substances taken \$	13. Were pharmaceuticals or merchandise taken? <input type="checkbox"/> No <input type="checkbox"/> Yes (Est. Value) \$
14. IF LOST IN TRANSIT, COMPLETE THE FOLLOWING:			
A. Name of Common Carrier		B. Name of Consignee	C. Consignee's DEA Registration No.
D. Was the carton received by the customer? <input type="checkbox"/> Yes <input type="checkbox"/> No	E. If received, did it appear to be tampered with? <input type="checkbox"/> Yes <input type="checkbox"/> No	F. Have you experienced losses in transit from this carrier in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes (How many) _____	
15. What identifying marks, symbols, or price codes were on the labels of these containers that would assist in identifying the products?			
16. If Official Controlled Substances Order Forms (DEA-222) were stolen, give numbers.			
17. What security measures have been taken to prevent future thefts or losses?			

CONTINUE ON REVERSE

LIST OF CONTROLLED SUBSTANCES LOST

Trade Name of Substance or Preparation	NDC Number	Name of Controlled Substance in Preparation	Dosage Strength	Dosage Form	Total Quantity Lost or Stolen
					Express Quantity in Dosage Units, or Milliliters for Liquids
Examples Desoxyn	00074-3377-01	Methamphetamine Hydrochloride	5 mg	Tablets	300
Demerol	00409-1181-30	Meperidine Hydrochloride	50 mg/ml	Vial	150 ml
Robitussin A-C	00031-8674-25	Codeine Phosphate	2 mg/cc	Liquid	5676 ml
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I certify that the foregoing information is correct to the best of my knowledge and belief.

Sign and Print Name

Title

Date